

# STUDENT INJURY REPORT

**Gender**                      **Name**                      **Age**                      **Date of Injury**                      **Time of Injury**  
Male ☐ Female ☐ \_\_\_\_\_ Yrs Old    /    /                      a.m. ☐ p.m. ☐  
**School** \_\_\_\_\_ **Date Reported** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Time Reported** \_\_\_\_\_ a.m. ☐ p.m. ☐

## **MARK ALL THAT APPLY**

<b>Grade</b> P-K <input type="checkbox"/> 4 <input type="checkbox"/> K <input type="checkbox"/> 5 <input type="checkbox"/> 1 <input type="checkbox"/> 6 <input type="checkbox"/> 2 <input type="checkbox"/> 7 <input type="checkbox"/> 3 <input type="checkbox"/> 8 <input type="checkbox"/>	<b>Period</b> <input type="checkbox"/> Before School <input type="checkbox"/> Class Time <input type="checkbox"/> Lunch <input type="checkbox"/> Phys. Ed Class <input type="checkbox"/> Recess <input type="checkbox"/> Unauthorized	<b>Incident Location</b> <input type="checkbox"/> Athletic Field <input type="checkbox"/> Classroom <input type="checkbox"/> Corridor <input type="checkbox"/> Driveway <input type="checkbox"/> Gymnasium <input type="checkbox"/> Playground	<b>Supervision</b> <input type="checkbox"/> None <input type="checkbox"/> Teacher <input type="checkbox"/> Aide/Monitor <input type="checkbox"/> Driver <input type="checkbox"/> Parent/Volunteer <input type="checkbox"/> Principal <input type="checkbox"/> Coach <input type="checkbox"/> Other _____
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**Activity During Which Injury Occurred**

<input type="checkbox"/> Adventure/Ropes <input type="checkbox"/> Baseball/Softball <input type="checkbox"/> Basketball <input type="checkbox"/> Classroom Activity <input type="checkbox"/> Climbing Bars	<input type="checkbox"/> Dodge Ball/War Ball <input type="checkbox"/> Dancing <input type="checkbox"/> Fight/Roughhouse <input type="checkbox"/> Football <input type="checkbox"/> Gymnastics/Tumbling	<input type="checkbox"/> Hockey (Flr/Fld/Ice) <input type="checkbox"/> Ice Skating <input type="checkbox"/> Jumping <input type="checkbox"/> Kickball <input type="checkbox"/> Lacrosse	<input type="checkbox"/> Rollerblading <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Skiing <input type="checkbox"/> Sliding	<input type="checkbox"/> Soccer <input type="checkbox"/> Swimming <input type="checkbox"/> Swinging <input type="checkbox"/> Tetherball <input type="checkbox"/> Throwing Snow/Rocks	<input type="checkbox"/> Track & Field <input type="checkbox"/> Volleyball <input type="checkbox"/> Other _____
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**Equipment Involved With Injury**                      ☐ **Not Relevant/None**                      ☐ **Faulty Equip.**                      ☐ **Equip. Misuse**

<input type="checkbox"/> Balance Beam <input type="checkbox"/> Bridges <input type="checkbox"/> Climbing Tower	<input type="checkbox"/> Glider/Trolley <input type="checkbox"/> Horiz. Ladder <input type="checkbox"/> Monkey Bars	<input type="checkbox"/> Pole Climb <input type="checkbox"/> Rope <input type="checkbox"/> Slide	<input type="checkbox"/> Swing (Tire) <input type="checkbox"/> Tetherball <input type="checkbox"/> Tire (Crawl)	<input type="checkbox"/> Platform <input type="checkbox"/> Swing (Reg) <input type="checkbox"/> 3 Level Bars	<input type="checkbox"/> Concrete Pipe <input type="checkbox"/> Other Object _____
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**Surface On Which Injury Occurred**                      ☐ **Not Relevant**                      ☐ **Wet**                      ☐ **Dry**                      ☐ **Uneven**

<input type="checkbox"/> Blacktop <input type="checkbox"/> Snow	<input type="checkbox"/> Brick Wall <input type="checkbox"/> Tile	<input type="checkbox"/> Carpet <input type="checkbox"/> Water	<input type="checkbox"/> Concrete <input type="checkbox"/> Wood Chips	<input type="checkbox"/> Dirt <input type="checkbox"/> Wood-(Treated)	<input type="checkbox"/> Grass/Lawn <input type="checkbox"/> Wood-(Untreated)	<input type="checkbox"/> Gravel <input type="checkbox"/> Wood-(Untreated)	<input type="checkbox"/> Ice <input type="checkbox"/> Other _____	<input type="checkbox"/> Mats <input type="checkbox"/> Metal	<input type="checkbox"/> Sand
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**Incident Type**                      ☐ **Intentional**                      ☐ **Non Intentional**                      ☐ **Unknown**

<input type="checkbox"/> Assault/Fight <input type="checkbox"/> Bite/Sting <input type="checkbox"/> Burn	<input type="checkbox"/> Collision w/person <input type="checkbox"/> Collision w/object <input type="checkbox"/> Drown/Near Drowning	<input type="checkbox"/> Electrical <input type="checkbox"/> Fall / Trip <input type="checkbox"/> Fall from Object < 5 ft	<input type="checkbox"/> Fall from Object 5-10 ft <input type="checkbox"/> Fall from object > 10 ft <input type="checkbox"/> Motor Vehicle Crash	<input type="checkbox"/> Poisoning <input type="checkbox"/> Other Trauma <input type="checkbox"/> Other _____
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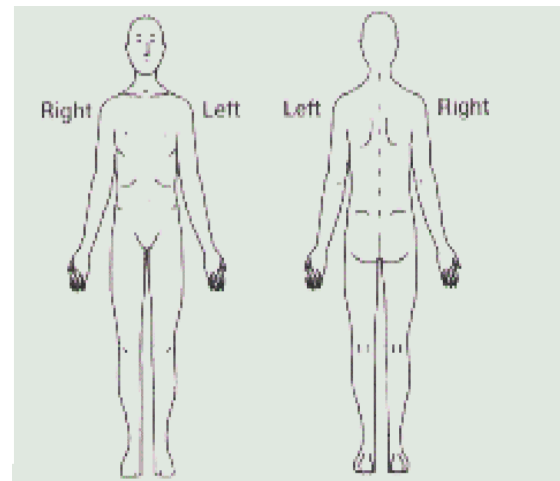
Action Taken (Mark all that apply)  
**Were Other Student(s) Involved** ☐ Yes ☐ No

Initials:    Time:

<input type="checkbox"/> Administration Notified	-----	-----
<input type="checkbox"/> Checked by School Nurse	-----	-----
<input type="checkbox"/> Checked by EMS	-----	-----
<input type="checkbox"/> First Aid Administered	-----	-----
<input type="checkbox"/> Parent/Guardian Notified	-----	-----
<input type="checkbox"/> Police Notified	-----	-----
<input type="checkbox"/> Remained In/Returned to Class	-----	-----
<input type="checkbox"/> Sent/Taken Home	-----	-----
<input type="checkbox"/> Taken to Emergency Facility	-----	-----
<input type="checkbox"/> Taken to Physician	-----	-----
<input type="checkbox"/> Other	-----	-----
<input type="checkbox"/> Unable to Contact Parent/Guardian	-----	-----

**Type of Injury**

☐ Abrasion  
☐ Bite  
☐ Bruise  
☐ Burn  
☐ Crushing  
☐ Cut  
☐ Dislocation/Fracture  
☐ Gun shot Wound  
☐ Knife Wound  
☐ Puncture Wound  
☐ Sprain  
☐ Splinter  
☐ Other \_\_\_\_\_



Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Person Completing Report

\_\_\_\_\_ Date

\_\_\_\_\_  
Administrator Signature

\_\_\_\_\_ Date

## **Follow-Up Repairs for Prevention**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_